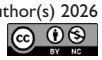
Special Issue: Disadvantaged and Vulnerable Consumers

Navigating Cross-Border Healthcare under Structural Vulnerability: The Role of Cultural Health Capital

Journal of Service Research
1–19



DOI: 10.1177/10946705261474264
journals.sagepub.com/home/jsr

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Abstract

This research examines how Hispanic women living in the US–Mexico borderlands coordinate household healthcare across two national service systems through the lens of cultural health capital (CHC). Drawing on multimethod ethnography using in-depth interviews, participant observation, and online diaries, we show how informants build and deploy navigational, social, familial, and linguistic capital to manage structural vulnerability in cross-border care. Findings demonstrate that women purposefully cultivate and allocate these forms of capital across three phases of healthcare shopping: pre-consumption, during shopping, and post-purchase. We identify consumer practices through which capital helps families navigate structural barriers, while also showing that such strategies emerge under conditions of constraint and do not eliminate exposure to risk. The study advances consumer vulnerability research by integrating structural vulnerability with CHC to theorize phase-specific capital orchestration and by specifying how intersecting vulnerability factors shape both exposure and response. We also translate these mechanisms into service design implications for providers, payers, and policymakers. In doing so, this research highlights the need for safer, more coordinated, and more culturally responsive care pathways that recognize the informal labor and cross-cultural expertise sustaining healthcare access in marginalized communities.

Keywords

consumer vulnerability, structural vulnerability, cultural health capital, cross-border healthcare, healthcare service systems

Introduction

The global healthcare industry is among the world's largest and most complex service sectors, yet the lived experiences of patients remain underexamined in both medical and service literature (Wolf et al. 2014; World Economic Forum 2023). While marketing and service scholars have increasingly emphasized the co-created nature of healthcare (e.g., Berry and Bendapudi 2007; Iacobucci and Popovich 2022; Spanjol et al. 2015), less is known about how consumers actively manage their care journeys when structural barriers limit access and affordability, even among those with insurance coverage. These barriers often appear as service touchpoint frictions, such as price opacity, scheduling delays, and fragmented coordination, that constrain consumers' ability to obtain and coordinate care. Responding to calls for greater attention to how intersecting identity factors shape marketplace experiences (Corus et al. 2024), we examine how consumers navigate structural vulnerability by drawing on informal knowledge, networks, and cultural resources to access healthcare services despite these constraints. One context where these dynamics are particularly visible is cross-border healthcare use among residents of the US–Mexico borderlands.

We study insured US consumers who actively shop for healthcare across the US and Mexican markets. Our primary focus is Hispanic women in the US–Mexico borderlands who cross the international boundary to obtain routine care in Mexico while retaining at least some healthcare services in the US. These consumers face human-centric systemic barriers to healthcare that we frame as "structural vulnerability" (Baker et al. 2005; Crockett and Wallendorf 2005). Building on Hill and Sharma's (2020) framework of coping with consumer vulnerability, we highlight the defensive mechanism of "creating new structures" (p. 561) as consumers cobble together healthcare across two distinct markets. Rather than "transcending" unmet needs or "rebelling" against consumption contexts, our informants establish alternative arrangements. We extend this perspective by showing how consumers not only create new

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structures but also mobilize evolving forms of capital to navigate them throughout the healthcare journey.

Within this landscape, Hispanic women play a central role as both patients and household healthcare coordinators. Prior work shows women, particularly Hispanic women, often serve as health decision-makers who shoulder the labor of scheduling, vetting providers, coordinating travel, and managing both financial and emotional burdens (Cohen et al. 2019). These roles are magnified in borderlands, where consumers weigh multiple suboptimal options across structurally distinct systems. We examine how Hispanic women manage routine cross-border medical care with strategic intentionality, drawing on social networks, linguistic fluency, and cultural familiarity. We also include male voices to juxtapose perspectives.

We draw on cultural health capital (CHC), or the nonfinancial knowledge, skills, relationships, and communicative resources patients use to navigate healthcare systems effectively. Specifically, the consumers in our study cultivate and deploy different forms of CHC at each stage of the shopping process (preconsumption, shopping, and post-consumption) as a defensive coping mechanism that allows for greater exploitation of capital within the context of garnering healthcare access. In doing so, the defensive coping mechanism provides an opportunity to overcome intersecting individual identities (i.e., ethnicity, gender) that are limiting their access to resources. By activating this capital across healthcare "shopping" journeys in two national service systems, our female informants often strategically coordinate healthcare access and decision-making for their families. In healthcare, CHC is particularly important because patients and caregivers contribute contextual expertise about their histories and constraints, even as clinicians retain professional diagnostic and treatment expertise.

Grounded in ethnographic fieldwork along the US–Mexico border, this study advances understanding of structural vulnerability in service contexts (Baker et al. 2005). We ask: *How do Hispanic women living in the US–Mexico borderlands develop and deploy cultural health capital to navigate structural vulnerability in transnational healthcare systems?*

Our contribution to the service and healthcare literature is primarily twofold. First, we show that cross-border healthcare shopping is not a passive coping response to consumer vulnerability but instead a strategic deployment of CHC. This reframes CHC as a dynamic form of capital that consumers cultivate, invest, and allocate across different phases of the healthcare journey. Second, we extend service research on vulnerable and underserved communities (e.g., Field et al. 2021) by demonstrating how borderland women's expertise reframes structural vulnerability. Their practices reveal how consumers navigate market-level barriers through "creating new structures" (Hill and Sharma 2020) while advancing theory on structural vulnerability (Baker et al. 2005; Crockett and Wallendorf 2005).

Theoretical Development

Consumer Vulnerability

Consumer vulnerability refers to the increased susceptibility of certain individuals or groups to experience unfavorable outcomes in the marketplace, often stemming from personal characteristics, contextual factors, or broader societal structures (Baker et al. 2005, 2015; Salisbury et al. 2023). Defined as "a state in which consumers are subject to harm due to restricted access and control over resources, significantly hindering their ability to function effectively in the marketplace" (Hill and Sharma 2020, p. 554), consumer vulnerability captures the sense of powerlessness commonly experienced by a consumer as a result of their individual characteristics and/or external factors common in consumption settings (Baker et al. 2005; Riedel et al. 2022).

Research has identified several distinct forms of consumer vulnerability which are shaped by different antecedents and service contexts. For example, financial vulnerability refers to limited economic resources that constrain a consumer's ability to access or afford goods and services, as well as income or socioeconomic status (SES). It can be caused by brief catastrophic events like health care emergencies (Himmelstein et al. 2019; Salisbury et al. 2023). Situational vulnerability can arise when consumers temporarily face heightened financial risk due to widespread events like the COVID-19 pandemic, for instance, which impact their ability to engage in the marketplace (Kirk and Rifkin, 2020). Identity-based vulnerabilities, such as those linked to gender, disability, age, race, or immigration status, may compound other forms of vulnerability and are often driven by social stigma and institutional or policy-level inequities that consistently disadvantage certain groups (Basu et al. 2023; Rosenbaum et al. 2017). Structural vulnerability arises from constraints that arise from the distribution of resources and opportunities and are "human-created" and systemic (Baker et al. 2005; Crockett and Wallendorf 2004). These forms of consumer vulnerability frequently intersect. Yet the distinctions among them enable a more nuanced analysis of how consumers, specifically Hispanic women in this study, respond to inadequacies in US healthcare.

The focus of consumer vulnerability research often narrows in on specific "vulnerable groups" or "vulnerable populations" (Shultz and Holbrook 2009) or marketplace manipulations and their consequences (Hill and Sharma 2020). One stream of vulnerability research typically examines "at-risk" or "disadvantaged" consumer groups, such as refugees, homeless individuals, incarcerated persons, disabled consumers, and those with low literacy or income levels, groups that are frequently underrepresented and marginalized in society (Rosenbaum et al. 2017). Interpretation of this focus may risk conflating vulnerability with the differential experiences of certain groups while overlooking

the structural aspects of vulnerability in the marketplace. A second stream of vulnerability research examines the impact of marketplace manipulations as opportunities and/or challenges for stakeholders, such as parents and policymakers, to mitigate these problems (e.g., Pechmann et al. 2020).

Hill and Sharma (2020) presented an organizing framework to extend the theory on consumer vulnerability. They describe how a lack of resources and a lack of control can lead to both *experienced* and *observed* vulnerability and evoke coping mechanisms. They argue that consumers facing vulnerability are often not passive recipients of their circumstances. Instead, they may adopt coping strategies that may provide cognitive, emotional, or behavioral escapes (Baker et al. 2005; Hill and Sharma 2020). Even some of the most vulnerable individuals, such as nursing home residents, can develop coping mechanisms (Sandberg et al. 2021). These strategies often take on one of three forms: *transcending*, *rebelling*, or *creating new structures. Transcending* involves rising above constraints to regain control, such as incarcerated individuals rejecting reliance on the prison commissary in favor of living on their own terms (Hill et al. 2016). *Rebelling* disrupts the resources of those in power, as when disadvantaged youth damage or steal luxury goods to retaliate against inequities (Ozanne et al. 1998). *Creating new structures* enables consumers to establish alternative consumption channels, affording them greater access and control (Crockett and Wallendorf 2004).

In the context of healthcare, consumer vulnerability often refers to the heightened and intersecting risks that certain groups face in obtaining and acting on health information and services (Sudbury-Riley et al. 2024; Tanner et al. 2020). This vulnerability cannot always be mitigated by delaying care or avoiding healthcare services altogether. It is often exacerbated and, as the different types of consumer vulnerability suggest, is often driven by age, health status, disability, health literacy, language barriers, and the complexities of navigating healthcare systems (Javor et al. 2023; Peñaloza 1995). For instance, minority populations or those from lower socioeconomic backgrounds frequently encounter challenges due to a misalignment between their available cultural resources and those the healthcare system recognizes (Dubbin et al. 2013). As a result, vulnerable consumers often experience suboptimal interactions with healthcare providers and poorer health outcomes (Kirmayer 2012). Complicating these intersecting factors, the post-Dobbs landscape (Fitzgerald et al. 2023) has further intensified consumer vulnerability, especially for women seeking maternal and reproductive healthcare. Insurance guidelines, extensive regulatory policies, treatment delays, and increasing costs all exacerbate vulnerability by creating a lack of resources and simultaneously limiting control of the structural environment. It is this multiplicity of lacking "resource-control" that Hill and Sharma (2020) propose as the antecedents to consumer vulnerability and the drivers of defensive coping mechanisms.

As a result of this lens of deficit, the consumer vulnerability literature often underscores the influence of a lack of financial, social, and cultural capital as antecedents to vulnerability (see Madden 2015 for an exception). Hill and Sharma (2020) describe financial capital as crucial for making market-driven decisions and accessing essential services. They also acknowledge that social and cultural capital, which are rooted in networks and relationships, may compensate for financial deficits by facilitating access to critical resources through communal support (Baker et al., 2005). Yet, we know little about how vulnerable consumers cultivate, sustain, or manage different forms of capital over time.

The CHC framework, by focusing on the capital individuals possess, rather than on the types they lack, allows us to better understand how consumers, particularly those experiencing intersecting identity and structural constraints, navigate these disparities by growing capital. By examining CHC, we respond to calls for further research on how alternative forms of capital can enable consumers to mitigate vulnerability and enhance their healthcare experiences (e.g., Hamilton et al., 2019).

Cultural Health Capital

CHC has been identified in the health literature as a critical asset for mitigating consumer vulnerability in healthcare settings (Saadi et al. 2023). It is defined as skills and knowledge of marginalized groups, developed specifically in response to "dominant oppressive structural forces" (Madden 2015, p. 147). It can range from understanding medical jargon and navigating health system bureaucracy to developing trusted relationships with medical service providers. CHC encompasses several dimensions of capital—familial, social, navigational, and linguistic—that are activated in response to healthcare exclusion from and disenfranchisement in majority healthcare spaces (Madden 2015). Familial capital involves kinship ties that facilitate community knowledge, while social capital includes resources from community members and social connections that can be helpful for navigating healthcare systems (Shim 2010).

Navigational capital is particularly important for minorities as it includes the ability to maneuver through systems that may not be designed with these communities in mind. Linguistic capital, involving the ability to communicate in multiple languages (e.g., Spanish and English), is also a significant component of CHC, particularly in cross-cultural settings such as cross-border healthcare (Madden 2015). This specialized collection of cultural skills, attitudes, and behaviors plays a pivotal role in the dynamics between patients and healthcare providers, influencing everything from service delivery to patient outcomes (Shim 2010).

Research on CHC parallels studies on consumer vulnerability by exploring how both the presence and absence of CHC can influence the quality of service encounters in healthcare

settings (Giraldo et al. 2021). While CHC can enhance access and quality of healthcare interactions, many studies tend to assume a deficit of CHC among certain populations, such as a focus on the lack of familiarity with the healthcare system (Rasmussen et al. 2021). It is further evident from the literature that, even when patients possess high levels of CHC, this does not necessarily prevent unsatisfactory healthcare experiences (Dubbin et al. 2013; Mann and Berkowitz 2023). This points to a more complex interaction between CHC and healthcare outcomes than previously understood.

CHC and the Compounded Vulnerabilities Facing Women

Most CHC research presenting aggregated data does not account for the unique challenges women face in US healthcare settings or the dynamic nature of the shopping journey (Amaro et al. 2024; Dubbin et al. 2013). This stems in part from an under-examination of how CHC is specifically utilized to mitigate vulnerability throughout the shopping journey. Of the studies that have examined gender and CHC, most focus on the outcomes of a lack of access to CHC (Giraldo et al. 2021). Few studies have shown how CHC is used to overcome structural and institutional barriers (see Kost and Jamie 2023; Madden 2015 for work on acts of resistance). At the same time, most conceptualizations of CHC refer to skills and capabilities (e.g., Mann and Berkowitz 2023; Manzer and Bell 2022; Shim 2010) and do not specifically study its use as *capital* or *wealth* that is used to build assets and future capital.

Yet, research shows women face heightened risks for vulnerability due to a combination of personal, social, and systemic factors (e.g., Uccheddu et al. 2019). For example, women face shifts in agency from autonomy and control to care for another in parenthood (Hanser and Zhang 2025). Few studies delve into the unique challenges women face in healthcare settings or examine how gendered norms shape the utilization of different forms of capital (see Krisjanous et al. 2023 for an exception). For instance, navigational capital, crucial for negotiating the healthcare system, may be constructed differently for women, particularly for border-crossers, considering factors such as educational status and familial ties (Amaro et al. 2024). Women's healthcare experiences are also intertwined with familial and social capital, with social support networks playing a crucial role in accessing and navigating healthcare services (Ireland et al. 2021). Moreover, the benefits of social capital may be more pronounced for women, influencing their healthcare choices and provider selection (Lindström 2004).

Many people who live near the border have been accessing more timely and affordable healthcare in Mexico for a variety of routine and specialized healthcare needs (Amaro et al. 2024; Raudenbush 2021). Some of the factors driving their journeys from the US include disparities in income, education, and access to health insurance or local healthcare providers (Castañeda 2017). Research indicates that women travel to Mexico for healthcare more frequently than men (Rivera et al. 2009), and descriptive accounts suggest that women conduct the majority of medical shopping abroad by US residents (Su et al. 2011).

The ability to manage and grow scarce resources is critical to women and their families because research has shown that women often face greater societal vulnerability than men (Fisk et al. 2023; Mende and van Doorn 2015). Women, particularly women of color, most often shoulder the healthcare burdens for themselves and their families (Woolf and Vinson 2024). Specifically, in many Mexican and Mexican-American families, women are traditionally assigned caregiving roles that extend beyond immediate family to include extended relatives (Molina et al. 2019). Despite potential shifts in gender roles among younger generations, the responsibility of women as the primary familial caregiver remains (Friedemann et al. 2014). These caregiving responsibilities, compounded by intersecting forms of oppression, continue to constrain financial capital growth for women (e.g., Lalani et al. 2025).

Focusing on routine medical care-seeking in Mexico in response to structural constraints (i.e., price opacity, limited provider access, high insurance costs) in the US, the current research examines how our Hispanic women informants attempt to overcome the health inequities they face by building, using, and managing CHC.

Methodology

This research is grounded in a constructivist, theory-building approach (Lincoln and Guba 1985), using ethnographic methods to understand how Hispanic women living in US–Mexico borderlands build, manage, and mobilize CHC in their roles as caregivers and healthcare decision-makers. To explore this phenomenon, we employed a multi-method design combining in-depth interviews, online diaries, and participant observation (e.g., Epp et al. 2014). Our fieldwork focused on multiple high-traffic healthcare crossing points along the Texas–Mexico border, where patients regularly access both markets.

Our broad definition of routine "care" included visits to doctors, dentists, pharmacies, clinics, and herbal medicine stores. All sixty-two participants were over twenty-five years of age, insured US residents, and had actively engaged in cross-border healthcare for themselves or their family members within the previous three months. In addition, they had also sought care with a US-based medical service provider within the past twelve months. An Institutional Review Board approved the study, and informed written consent was obtained.

Sample and Recruitment

Of the sixty-two participants, forty identified as women and twenty-two as men. While our primary focus was on the experiences of Hispanic women, we included male participants to juxtapose and triangulate accounts of family care practices,

decision-making dynamics, and the gendered distribution of health labor. Their inclusion enabled a clearer understanding of how health-related responsibilities are negotiated within families. Notably, men often described women's roles in ways that echoed women's self-reports, reinforcing the centrality of these women in managing cross-border care. The vast majority of participants self-identified as Hispanic, consistent with the demographics of the region.

Participants were recruited through a professional firm specializing in research with borderland consumers. Inclusion criteria required regular healthcare usage in both the US and Mexican markets: informants had made cross-border healthcare purchases of at least $25 on two or more occasions in the past year and intended to continue such behavior. Respondents came from diverse towns within one-hundred miles of the Texas–Mexico border and varied in gender, age, education level, income, family size, and frequency of healthcare usage. All participants held US-based health insurance (employer or marketplace; one through their parent). This included US-based healthcare plan(s) providing US medical, dental, and vision services. See Web Appendices A and B for demographics, purchased items, and expenditures.

This research was conducted in two phases (in September and October of 2020 and in June of 2022)—a time marked by significant healthcare disruptions, heightened uncertainty, and border closures. We interviewed these informants in two groups because the first group of thirty-two informants reported some changes in their purchasing and travel behaviors due to pandemic restrictions. These conditions shaped the availability and affordability of healthcare services along with the emotional and logistical burden placed on consumers navigating two systems. The pandemic context likely influenced participants' decision-making and risk assessments, which limits the generalizability of our findings. However, they also illuminate how structural vulnerability intensifies under crisis, offering insight into the resilience and adaptability of cross-border consumers. As such, our findings should be read with this temporal lens in mind.

Our sampling strategy focuses on insured US residents in border communities who routinely use both US and Mexican healthcare markets; therefore, our findings are not intended to represent all forms of medical travel or all cross-border healthcare consumers. This boundary was intentional, reflecting our interest in the lived experiences of working- and middle-class families who cobble together healthcare transnationally.

Data Collection

Semi-structured interviews were conducted via video call and recorded for transcription. While the majority of participant interviews were conducted in English, some participants preferred to be interviewed in Spanish. Spanish interviews were translated by a transcriptionist familiar with what is commonly termed "border Spanish," a unique blend of English and Spanish that reflects the cultural and linguistic landscape of the border region. Interviews were complemented by online diaries, allowing participants to document their real-time decision-making and care experiences over the course of their healthcare "shopping" journey. Diaries included text, video, and photos uploaded during pre-care, in-care, and post-care phases (e.g., Bone et al. 2014). The inclusion of participant-generated video and photo diaries added valuable depth to our findings by capturing more real-time decision-making and emotional responses of cross-border care. These multimedia entries often revealed subtleties that were less visible in retrospective interviews—for example, revealing participants' facial expressions when discussing trust in providers or highlighting the tone of voice used when navigating price negotiations. The temporal immediacy of these entries helped contextualize themes such as risk management and planning complexity, offering a layered perspective on how participants developed and deployed CHC throughout each phase of the shopping process. These diary entries also captured moments of uncertainty, improvisation, and resilience that were central to our interpretation of CHC as a dynamic, situated resource. The interview protocol and online diary prompts (see Web Appendices C and D) collectively explored participants' familial roles, healthcare navigation responsibilities, service and product choices, affordability concerns, and perceptions of quality.

We also conducted ethnographic observation, spending approximately twelve hours in border towns, including guided shopping visits with participants in Mexico. These fieldnotes, totaling 1,843 pages, enriched our understanding of context and care behaviors in situ. Researcher positionality was a strength: our all-female research team included dual US–Mexico citizens, healthcare users in both systems, and caregivers themselves, enabling both emic and etic perspectives.

Data Analysis

We employed a grounded theory approach (Glaser and Strauss 2017) to analyze interviews, online diaries, and fieldnotes, with the aim of generating theory rooted in the lived experiences of our participants. Our analysis was both inductive and iterative, informed by principles of interpretive consumer research and attentive to emic meaning systems.

We began with open coding, in which three members of the research team independently coded a subset of transcripts, diary entries, and observation notes using Dedoose (Salmona et al. 2019). The goal at this stage was to identify salient participant concepts, recurring language, and patterned experiences related to healthcare decision-making and cross-border care navigation. Codes were largely descriptive at first, capturing participant references to cost, trust, navigation, family roles, and perceptions of care quality. Following this initial round, the team convened to compare code applications and resolve discrepancies through dialogue. This process enabled a reflexive calibration of our coding lens and the development of a shared

codebook that we applied across the full dataset. We maintained detailed memos throughout this process to track emerging insights and note potential theoretical connections.

Next, we engaged in axial coding (Corbin and Strauss 2008) to explore relationships among categories and organize codes into broader domains. This included mapping participant behaviors across the three shopping phases—pre-care (planning and comparison), in-care (procurement and negotiation), and post-care (evaluation and follow-up). By analyzing how informants acted across these temporal stages, we traced how navigational, social, linguistic, and familial CHC were built and mobilized over time. The analytic focus at this stage shifted from what participants did to how and why they did it, and with what outcomes.

Throughout the process, the team engaged in constant comparison across participant types (e.g., gender, age), data sources (interviews, diaries, observation), and temporal moments. Regular team meetings served as spaces for collaborative sensemaking, enabling us to revisit early interpretations and check for consistency and credibility across the growing dataset. This team-based analysis structure ensured that our findings were not idiosyncratic or overly individualized, but rather reflected consensus-building and rigorous triangulation.

Thematically, we observed that participants' healthcare behaviors reflected strategic responses to structural vulnerability along with identity-related factors. This enabled us to theorize women's CHC practices as forms of deliberate resource cultivation, allocation, and optimization, akin to how firms manage intangible capital under competitive constraint.

Finally, the team returned to the full dataset using focused coding to confirm the robustness of emergent themes and identify compelling examples. By combining grounded theory procedures with interpretive, theory-informed analysis, we generated a nuanced account of how Hispanic women living in the US–Mexico borderlands navigate cross-border healthcare systems—not simply as vulnerable consumers, but rather as strategic actors managing risk and capital under constraint.

The results of this theorizing are presented next. First, we show how CHC operates during pre-consumption practices by explaining how strategic planning and capital building are cultivated and deployed. Second, we specify how these women deploy and leverage capital while shopping in Mexico. Third, we specify how post-shopping practices reflect capital allocation and reallocation. Each phase of the shopping journey is explored through informants' depictions of their responses to structural and individual identity-related vulnerabilities.

Findings

This CHC structure serves as an analytical framework for bridging the role of women as healthcare caregivers to health managers. Consumers shop for healthcare in Mexico in response to multiple systemic constraints such as high costs, price opacity, inability to see specialists without multiple visits, lengthy waits to see a physician in their area, and limited therapeutic access to medications. Detailed manifestations of system-level constraints, which have been well-documented in others' research (Madden 2015; Vargas Bustamante 2020; 2023; see Web Appendix E). Here, we focus on how consumers mobilize CHC across pre-consumption, shopping, and post-consumption phases to cope with these barriers.

At each shopping phase, the women in our study use and build navigational, social, linguistic, or familial capital in their shopping experience to cultivate, manage, and deploy their capital in response to the cumulative effects of structural barriers to care. Three themes emerge from these data indicating how and when different forms of capital become critical: (1) pre-consumption practices: strategic planning and capital building, (2) shopping practices: deploying and leveraging capital, and (3) post-purchase practices: capital allocation and reallocation. We further examine the different forms of CHC used at each stage. Collectively, these data reflect the resource-management actions undertaken by women in response to structural constraints that intersect with personal identity factors. Our use of the label "capital" is critical to accurately depicting the strategic acumen, resourcefulness, and decision-making labor that these informants, mostly Hispanic women, bring to navigating complex, transnational care systems. Nevertheless, we acknowledge that this metaphor risks reinforcing value hierarchies that equate worth with economic rationality. Our intent is to underscore the need for healthcare systems that recognize and respect women's caregiving labor and humanity—regardless of their ability to perform as institutional entrepreneurs (see Table 1).

Pre-Consumption Practices: Strategic Planning and Capital Building

Extensive strategic planning and capital building preparations begin weeks prior to crossing the border for healthcare. Much like firms entering a new market for the first time, these informants describe capital investments (i.e., short-term and long-term costs), new technologies (i.e., new and alternative treatments), cost shifts (i.e., changes in insurance policies), and functional uses for products and services. Their preparations aim to build and leverage navigational, social, and familial capital while obtaining benefits from the flexibility of seeking services transnationally. Female participants and one male participant (a single father) described actively building and managing this process for themselves, their families, and sometimes close friends. Apart from the unmarried father, single or married men described efforts undertaken in collaboration with female partners or family members and often with the guidance of women's recommendations for when and where to travel for care.

Strategic Planning and Risk Mitigation. Similar to firms assessing market risks and opportunities (Schriber and Löwstedt 2018), participants develop their knowledge and capabilities by

Table 1. Consumer Vulnerability and Asset Orchestration Strategies.

Theme	Subtheme	Stage	Primary Forms of Capital	Description
Theme 1: Pre-Consumption Practices: Strategic Planning and Capital Building				
	Strategic Planning and Risk Mitigation	Pre-Border Crossing	Navigational Capital	Developing knowledge and capabilities to navigate both healthcare systems and the physical environment of Mexico.
	Building Familial and Social Capital	Pre-Border Crossing	Familial and Social Capital	Integrating family knowledge and ties prepare for healthcare shopping trips; developing and leveraging cultural practices, such as the use of traditional medicines to create social capital.
Theme 2: Healthcare Shopping Practices: Deploying and Expanding Familial and Social Capital				
	Leveraging Familial Health and Growing Market Knowledge	During Healthcare Shopping	Familial Capital	Relying on family members familiar with Mexico to guide healthcare shopping activities.
	Social Capital through Networking	During Healthcare Shopping	Social and Linguistic Capital	Networking with others to gather advice and recommendations, reinforcing social ties.
Theme 3: Post-Purchase Practices: Capital Allocation and Reallocation				
	Sustaining Cultural Health Practices	Post-Purchase Consumption Practices	Social Capital	Sustaining and adapting cultural health practices by bringing back traditional remedies.
	Stockpiling and Redistributing Healthcare Resources	Post-Purchase Consumption Practices	Familial Capital	Stockpiling and distributing healthcare resources to maintain community health resilience; strengthening familial ties by sharing purchased healthcare resources with family members.

assessing potential benefits and challenges of cross-border healthcare. Faced with choosing between service systems on either side of the border, both of which they considered suboptimal, women described routinely seeking advice from other women to help build and bridge their skills, acquire new knowledge, and assess the characteristics of a dynamic service environment (Helfat and Peteraf 2015). Single young females often referenced seeking advice from older female family members (primarily mothers, grandmothers, and aunts) when seeking new service providers or as a result of failed service encounters in the US. Efforts to seek care in Mexico for the first time were typically a result of limited ability to access timely care, multiphased treatments that were too lengthy, gatekeeping medication these informants felt were suitable treatments, high costs, and opaque prices.

Overall, monolingual female informants (all of whom spoke English only) were more likely to engage in extensive strategic planning than bilingual informants. Those who could not speak Spanish did research online and asked friends and family for referrals. For example, Alicia (40s, married, nurse) first sought provider recommendations from older female friends and family as well as her boyfriend (who resided in Mexico), then personally researched and interacted with recommended providers before traveling to Mexico. She said:

> Once I get their name and information, I Google them. And of course I contact their office. And. . . really it is based on how well the person answers the phone and is able to answer all my questions. And a lot of these receptionists, they speak English really well. Especially since my Spanish is not a hundred percent. And even some are able to speak fluent English, so that's perfect. Really, Google helps out a lot. I use my smartphone or my computer to research them.

Emma (40s, married, contract specialist) also said that her selection of care providers for herself and her children is "always by recommendation." In a video diary during a visit to Mexico, she described her experience of being handed cards for businesses to visit for healthcare services, referring to them as "shady and not very honest." For this reason, she said she relies exclusively on word of mouth to choose healthcare providers in Mexico. She described herself as the "manager" for all aspects of her life: her employer, for a local charitable organization she assists on a volunteer basis, and for her household. She stated she manages "everything" and works hard to maintain knowledge about changing constraints on her healthcare access and cost to avoid consequences to the family's health and finances. Other women, such as Nina (40s, married, nonprofit coordinator), looked for recommendations from family members and female friends for specific service providers even when they are not in immediate need of care to have a list of options available.

In addition to cultivating recommended providers, all female informants described some apprehension about traveling to

Mexican border towns due to cartel or other violent activity. Stranger violence against women is common in northern Mexican border towns (Staudt 2008) and many informants implemented various risk mitigation efforts prior to shopping. Many female informants have learned specific tactics from other women to reduce their susceptibility to crime, such as leaving their cars on the US side of the border and hiding money in different bags and several places on their bodies (e.g., inside a bra or shoe). Several female informants with school-aged children acquired new forms of navigational capital by learning to check news reports on Facebook via "mom groups." Female informants also sought insights from WhatsApp groups or the news on the day they planned to travel. If violence patterns appear to be on the rise during the week of their market entry, they typically delay. For example, Nancy (40s, married with children at home, teacher/childcare) said:

> There's a certain page on Facebook. I guess it's from the people from across that will start giving heads up. 'Cause to be honest with you, since we are a border town, we do have a lot of family members over there. So in that community, they'll give you a heads up, hey, just so you know, there's word on the street, don't come today, or stuff like that.

Because informants' video diaries often reflected their feelings immediately upon returning to the US, we were able to see both their facial expressions and how they depicted their trips, and many described feeling anxious and fearful until they stepped back on US soil. Both men and women showed and described relief, but only female informants reported online planning activities to diminish potential threats. Male informants primarily focused on traveling to and from Mexico during daylight hours. For example, Edgar (40s, single, customer service) sighed in relief in a video diary:

> I'm glad that we're back safe. I was a little anxious, you know. I always get anxious when we cross over. You just never know what's gonna happen.

Like other monolingual male informants, Edgar described anxiety and fear upon crossing the border bridge. However, he found some solace in relying on his bilingual girlfriend who was born in Mexico because she "knew" which streets and clinics were "better areas" (to avoid crime).

Like other informants with limited navigational capital, Zaneta (30s, single parent, social services case worker) had assistance. In her case, her mother, who lived in Mexico for a long time, travels with her to give her extra help navigating the city. She stated:

> I mean, 'cause of the violence over there, how things have been going [I'm cautious]. But I do go during the day. I go with my mom, and like we just go and come back. We don't go and eat or any of that stuff.

Zaneta also said, "I won't drive over there [in Mexico]. They drive too crazy, I get scared. And, they might, um, steal your vehicle." Zaneta mentioned that when she returns to the US she feels

> [s]uper relieved. Like, there's a toll booth, and you pay your toll. . .. Once you pass the toll booth, like it's a long walk, about a 15 minute walk, across the bridge, and once I pay that toll, like I feel relieved. . .. I'm very like that. I just think, oh, [about] the worst case scenario. Um, you know, I'm just prepared for like the worst basically.

Michelle (30s, married without children, medical assistant) reported leaving her car in the US for fear of it being stolen after learning about the problems with car thefts:

> I don't drive across the border. . .. I leave my car. I park it downtown, 'cause I don't wanna. . .have the chance of not having a car when I come out. So I park it here, then I'm walking around downtown [at a border city on the US side], and seeing how. . .seeing how everybody's reacting then, before I cross over [into Mexico].

Other female informants described how they navigate legal constraints (e.g., limits on personal medication) to avoid problems with customs officers from both countries to alleviate the added risk of delays or confiscation of goods. For example, Iris (50s, married without children at home, unemployed), who has extensive cross-border experience, redeploys her navigational capital during each visit to Mexico. She always brings a "special suitcase" to avoid problems with US customs. She said,

> I take a special suitcase, like the little duffle bag, and I put 'em all [teas, medications] in there. But like I tell you, I also bring the receipt. Just in case that in customs they ask me, and which they don't. If they see that it's tea, they're okay with it. You know, but I always bring the label. I don't wanna have any problems, and them. . .thinking I'm tryin' to smuggle anything in.

In a video diary, Angel (40s, married with children at home, Contract Specialist) reflected in real time on ways she had just deployed navigation capital despite her husband's fears when crossing back into the US with medication. She said,

> My husband was kinda nervous. He was like, "I have all this medication, oh my God, what if they stop me?" This and that. "I have Tramadol with me." And I'm like, just give it here. My husband doesn't have a passport, so he uses his birth certificate to cross. And I have a passport, so I will say you just give it here, and I just cross easily. So, I felt okay.

Collectively, these tactics and strategies for growth represent efforts by these women to orchestrate new ways of building their navigational capital for themselves, their families, and with other women for the purpose of improving their familial health and remaining timely in their understanding of the Mexican market and its providers. The types of CHC (i.e., navigational, linguistic) reduce structural vulnerabilities such as safety risks in border towns and legal constraints on medication but are managed similarly to financial capital.

Building Familial and Social Capital. Women's strategic planning and desire to replicate ways of caring formed the foundation for their healthcare strategies and their efforts to build familial capital. The sharing of health customs across generations is commonly seen in ethnic minority populations (Kagawa-Singer and Chung 1994) and is consistent with prior work suggesting that a collective of leaders, partners, and the broader ecosystem co-creates culture (Sharma and Conduit 2016). Their efforts to build familial capital offered an opportunity for them to overcome disenfranchisement from the US healthcare system while reinforcing their forms of familial capital (Hill and Sharma 2020).

In obtaining cross-border care, informants primarily deploy and redeploy their familial capital to strengthen horizontal ties (i.e., similar status among family members) to ensure the appropriate response to a family member's healthcare need (e.g., see Schriber and Löwstedt 2018 for discussion of asset orchestration and horizontal ties among firms). Often this includes women (primarily mothers) coordinating care and remedies for themselves, their children and partners, and their parents. For Olivia (40s, married with no children at home, case worker), the use of two markets and, in particular, the herbal remedies sold in Mexico, strengthens her familial bonds with other female family members. She reasoned that "cultural influence" may be why she buys products that are common in the US in Mexico. She said:

> I guess in our culture, it just, you know, it's been brought down through the generations where, if you get a cold, you know, they start, you know, giving you some herbal tea instead of, you know, actually going for that. . . uh, that Tylenol, or going for that, uh, you know, uh. . . Metamucil or whatever, you know, whatever they. Even though they're over-the-counter medications, [they're] still medication. So, I guess that that also influenced me into [seeking these products in Mexico].

Annie (40s, married with no children at home, paralegal) discussed in a video diary that her current pre-consumption plans included visiting the same Mexican pharmacy she has utilized for over twenty years which had been recommended to her by her mother-in-law. In line with female informants' depictions of themselves as the managers of their families' care, male informants, even more than female informants, said they seek healthcare advice from family members and close friends, generally women. They described the women in their families as the "keepers" of this familial wisdom. For example, Gregorio (20s, single with no children, student), suffering from depression and anxiety, described how a female family member goes to Mexico for him and purchases the items that will best suit his needs. He said:

> A family member goes [to Mexico] and they buy. So it's, what they usually buy is just like, uh. . . I guess herbal medicine, or, or just more natural stuff. They, it's my. . . step, grand aunt, and they're kinda like, they don't trust anything like Western. Like as far as [medicine]. So, she's like, you have this goin' on, you're gonna, have this [medicine]. She's given me prickly pear, and that's s'posed to help with cholesterol, help lower it. It's mostly herbs, more than anything.

While Gregorio did not report specific skepticism in Western medicine, he followed the direction of his elder female family member and her reported skepticism and distrust of the US-based healthcare system and Western medicine. He intended to implement his step-great aunt's directives and described these efforts as an intergenerational set of familial practices.

Jennifer (40s, married with children at home, gym teacher) coordinates her mother's care because while Jennifer speaks English fluently, her mother does not. Jennifer said that doctors' refusal to give her mother care because she does not speak English is one of the reasons Jennifer does not trust US doctors. In an illustration of how broad her disgust is, she said, "I believe that the United States makes us sicker than we really are, or than we need to be." Because of this mistrust, Jennifer uses the Mexican market and her knowledge of its treatments to offer her mother improved care, pivoting between markets for what she sees as better treatments.

Shopping Practices: Deploying and Leveraging Capital

When seeking healthcare in Mexico, women participants actively generate and utilize multiple forms of capital, much as businesses leverage financial and social capital to grow and sustain operations. For example, they leverage their information-sharing and networking skills and expertise via real-time use of social media and apps (e.g., WhatsApp) to access the best prices and locate available providers and to coordinate visiting family in Mexico in conjunction with their healthcare trips. They do so in response to their limited ability, in the US, to garner timely and affordable care. Specific efforts to build social capital and increase network ties to leverage embeddedness to obtain good care are discussed in further detail below.

Deploying Capital. Women participants draw on social, familial, navigational, and sometimes outsourced linguistic capital when coordinating their efforts to travel to Mexico by using a traveling companion (Hamilton et al. 2021) and by educating themselves about healthcare treatments as well as infrastructure norms and legal policies. Older female travel companions tend to serve as guides for protection, advice, and translation, while channeling their linguistic capital during shopping experiences (e.g., price negotiation). They also provide an opportunity to build deeper familial and social relationships by bonding over shared journeys for health care. Informants have learned to navigate the market to find providers close to border crossing checkpoints and US customs to avoid more difficult travel further into urban areas, to avoid the risk of violence and to alleviate the need for a car. They also navigate quickly to avoid losing

their way, which costs money and time. For example, Edith (30s, single with children at home, case manager) rents a hotel room within a block of a walking-entrance, so that she can access care near the border early in the morning and return back to her home a few hours away. She avoids entering further into the city because of concerns that drug cartels may be operating. Edith deploys her navigational capital, visiting health and dental clinics near "the [border] bridge." As she said, she can always see the bridge from the location of the care she received, so that she can return to the US as quickly as possible should cartel violence arise. An exception is Alicia, who drives a vehicle in to buy healthcare products to reduce costs and visit her boyfriend. She stated in a video diary:

> I don't go [to a pharmacy] too close to the border, because then it's just more expensive. Doesn't matter which pharmacy it is. You gotta go a little further in. Like here in El Paso, everything on the west side is more expensive. And the east side is cheaper. Even though it's a nice area too.

Alicia's decision to travel farther into Juarez reflected her own navigational capital, which reflected her desire to save more money, even if it was only a few extra US dollars. Several informants had familial ties with medical providers in the US and Mexico, and they would deploy their familial capital. These informants often relied on their family and friend networks to seek medical advice and avoid the traditional process of visiting a US-based physician. For example, Margaret (40s, married, children, food service) contacted a family member in Mexico when she thought her child was sick and could use an antibiotic. She said:

> I also have a cousin in Mexico who is a pediatrician. So I'll usually ask her before I buy anything, to make sure, hey, is this a good brand, or is this good for my kids to take. Mainly because, if it's something simple like an earache or something like that, if I see my kids messing with the ear, or somethin', like, I don't wanna have to go to the doctor. I just feel like it's more of a hassle to have to set up the appointment, go, and pay a certain amount for something that I kind of already know could be treated at home. So I'll just like, give 'em one of the antibiotics to prevent having to go to the doctor [in the US].

Other informants accessed market knowledge about specialized providers in different parts of Mexico. For example, Lilia (50s, Single with no children at home, secretary) leveraged the recommendations of her social network to see a gynecologist in a city several hours from the border in Mexico. She explained that she heard from friends who had traveled to Monterey or Mexico City for care that it was "different."

> You know, of course the border's a little bit different than when you're, you know [further from the US–Mexico border]. But, when you go a little bit more in [Mexico], you have these hardworking, good doctors. That are, you know, looking at people and helping people. And here [in the US], you can pay a doctor and they talk to you for like two minutes, five minutes, and they say thank you; next. And so. . . I think it's just different; I don't know if it's the culture, or, or what, but it's. . . it makes a difference to me.

Many female informants reported that US-based service encounters are systematically inferior to Mexican encounters because US providers always appeared "in a hurry" due to insurance constraints. Leveraging social capital to obtain care they felt was better quality was common. This illustrates how this type of CHC is built, managed, and then deployed to mitigate compounded vulnerabilities (i.e., structural and identity-based). Angel drew on her "be an informed and educated Hispanic woman" identity but said that her constant quest for market knowledge exhausts her. She described their ethnicity and gender combination as factors leading to further "work." As a woman of color, Angel said, she has expected her whole life that people will "look down upon" her (consistent with Hill et al. 2016). Yet, she expressed some guilt about having more information than others in her own (Hispanic) social networks because of employment in the medical field and her college degree.

Expanding Social and Familial Capital. Growing social capital also occurred through strategically networking and building non-medical and medical-related service tasks into one Mexico day trip. Such efforts mainly concerned horizontal ties (e.g., friends, relatives of the same generation) rather than higher-status or elder family members (i.e., vertical ties). For example, because women often reported visiting Mexico with other women to ease their safety concerns, they also often stopped for lunch and engaged in brief beauty treatments to both socialize and reward themselves for their efforts. For Edith, her visits to Mexico with family and friends offered two-fold benefits: more affordable access to healthcare products and services and time to socialize with family. She often traveled with her aunts or mother and often had pedicures with them during their visits to Mexico. Similarly, Annie reflected in a video diary on how much she enjoys visiting Mexico with her mother-in-law, who travels from Minnesota, to cross the border for medication, as they often also receive spa treatments.

For Lilia, pedicures are essentially a form of healthcare. She has diabetes and cannot reach her feet to trim her nails or care for the skin. Pedicures were cheaper in Mexico than in the US, and she leveraged social capital through going to places her aunts recommended. However, she started having a bad skin reaction following pedicures in Mexico and, at her mother's suggestion, began obtaining pedicures in the US instead despite the higher expense.

In general, it seems that higher SES participants and participants with less cross-border experience were more likely to gravitate toward what they deemed necessary purchases (e.g., diabetic medication). These participants may wish to do most of their shopping in the US since they have more resources to do

so. On the other hand, lower SES participants and participants with more cross-border experience seemed more likely to purchase non-healthcare items such as groceries and household, elective spa treatments, and gasoline.

Another strategy women participants used to leverage their social capital was their negotiation skills. For example, when Gisel (30s, married with children, utilities worker) received a medical bill in the US, she negotiated with providers to garner the lowest monthly payment possible to pay it off. She attempted to ask for a cash price, sought the lowest monthly payment possible because she does not pay interest, and, in other cases, renegotiated payment plans regularly. These negotiation skills serve to alleviate financial vulnerability. Gisel also said she intends to get testing in Mexico because she has not been able to obtain insurance coverage for hormone replacement therapy. Further, she suspects from her discussions with other women that her doctor in the US is ignoring treatments that could relieve her symptoms. She explained:

> I've been wanting to do hormone testing for a long time, and my OBGYN keeps saying that I'm too young, therefore the insurance is not gonna cover it. And I feel like a lot of the symptoms that I get are hormonal. And so I've actually asked, and it's, I believe [hormone testing is] a hundred dollars over there [in Mexico]. So I've been thinking of actually going over there and just getting tested over there, to figure out, you know, what's going on. And perhaps if I have that. If, perhaps if I have that proof to show to [my doctor], then she's gonna be more inclined to say, okay, well we can get you tested here, so we can get you the care that you need.

Similarly, in a video diary, Marisol M. (30s, married without children, transportation services) described how she negotiates appointment times, reflecting on the effort she undertakes to achieve all that she plans to have a productive trip to Mexico. She stated:

> And. . . you know, sometimes, for some reason, there are some businesses that you make an appointment, and then they'll call you unexpectedly to change it. This is not the first time. Um. . . but that is one thing that, um, is kinda overwhelming, because I don't have the liberty to go. . . just any time.

Some women leveraged their social network to afford costly care while others created their own treatment paths. One informant said that she and a friend were sharing a GLP-1 weight loss drug prescription, each consuming half a dose and splitting the cost. In this way, the informant said they could control the prices and the amount of supply they retained.

Post-Purchase Practices: Capital Allocation and Reallocation

These informants manage and redistribute CHC within their families and broader social networks. Their efforts are twofold: first, they work to create and transmit sustainable cultural health practices, ensuring the well-being of their family and community; second, they stockpile and distribute resources, such as medications, to minimize disruptions that would be complex, given their child-rearing and employment responsibilities. These actions resemble firms' reinvestment of profits to sustain growth in volatile environments, as the women leverage and redeploy their capital to maintain stability and resilience in their households.

Capital allocation for these women is much like resource or asset allocations made by organizations to distribute their scarce resources and enhance their competitive advantage (Lovallo et al. 2020). Managers engage in capital allocation and reallocation for the strategic use of externally sourced and internally generated capital. Female informants engage in similar practices in two ways. First, they create and teach sustainable cultural health practices to their family and broader social connections to increase their well-being and better allocate future temporal and financial resources. Second, they stockpile and distribute products (i.e., medications). These efforts are much like firms' efforts to reinvest profits for sustained growth.

Sustaining Cultural Health Practices. Women participants, acting as health managers, operate outside of the formalized healthcare system to ensure their cultural practices are sustained through well-designed processes to teach family and friends about their efforts to reduce the costs of the care system, ensure cultural traditions about healing aids are retained, and ensure family members across all genders are aware of their efforts to sustain the well-being of their connections. For example, ancestral medicinal practices such as teas are a popular commodity many informants said they "stock up on" in Mexico. For instance, Juliana (50s, married with children at home, unemployed) said:

> I love to go. . . [to Mexico] and, and, and just get, where they have tons of teas of different kinds. And people will ask me, can you bring me this, this tea or that tea. And I'll tell 'em, yeah, if I find it, I'll bring it to you.

Juliana uses her navigational capital in Mexico to locate herbal teas recommended by elder women in her family and also shares the teas with family members upon her return.

Sofia (40s, married with children at home, homemaker) also purchases teas and other herbs to share with her family. Like other informants experiencing healthcare exclusion due to their ethnic minority status (Madden 2015), Sofia described how her Hispanic heritage and her own relationship with her mother are beneficial for improving their health. She said:

> Like I have that, it's that, like, heritage in me. Like I just have those teas, the herbal teas. And like, you know, just like some stuff that my mom would do, and I just can't let go of everything.

She purchases teas because they are a natural way to improve her health. Yet, she referenced a tension between her mother's

ways of healing versus modern medicine. Sofia also adds her own knowledge of both healthcare systems to the family's current practices. She once believed that Mexican doctors were better than US doctors but has come to feel differently. As she said:

> I believe that I thought, you know, it's better over there [in Mexico]. Oh, doctors here, you can't trust the doctors in the US. You know, doctors in Mexico are better. You get better real quick. You know, you always hear like, oh those doctors in the US, they, they're so expensive. And they're really not doing anything. All they're just telling you, oh you're fine, come back in two weeks or whatever. So I kinda believed it at first. You know, you grow up hearing that, and I guess you would go to Mexico, you feel sick, and you go and they give a shot, and the next day you're fine. So in your mind you're like you're like, okay, it, they're better.

Sofia's life has changed, though, and she now has greater trust in US doctors:

> But then like once I started, like once you have kids, it's like I don't wanna risk my kids over there. Like you know, it's different. Once I had my kids, it's like, especially because they were like born with asthma, and they were preemies, so it's just totally, I saw how they got better here [in the US], and I was like, I don't know, I started trusting doctors here now, so. It's so weird. Like after my kids, I totally don't trust the Mexican doctors, but I still buy the medicine over there, so, I don't know. I don't take it; my husband does.

While neither the US nor Mexican markets provide optimal options, Sophia L. credits her ability to navigate both markets and her years of shopping with her mother for the investments they have made in their family's health and well-being.

Stockpiling Inventory and Reallocating Healthcare Resources. A common practice among these informants (regardless of gender) is the stockpiling and redistribution of healthcare products and related knowledge to family and friends. This includes medications such as antibiotics, NSAIDS, and insulin in some cases. However, the redistribution and know-how associated with "natural" or herbal "concoctions" and teas was exclusively shared by women, according to all informants. They often described elder females within the family and their community who shared both the products (e.g., teas) and the knowledge of its purpose. Emily (40s, married with children at home, food service worker) reported how she helps her family and close friends when she travels to Mexico:

> Sometimes in my family. . . I have a sister-in-law, and sometimes my friends who can't go to Mexico, they need some type of medication, they'll ask me.

Gabriela (50s, married without children at home, sales manager) also buys more medications and teas than she needs for her own family, although not as much as her mother used to. To share these drugs and their cultural knowledge of "healing methods" provides an opportunity for women, acting as managers within their familial and social units, to quickly act (i.e., not wait for a US doctor appointment that may take days or weeks to obtain) based on their own intelligence and established processes to direct resources to the right (e.g., clean, available services from a doctor) places in the family and social circle. For example, Edith said that on a recent trip to Mexico,

> I also bought some antibiotics, 'cause my mom wanted them, so we bought that over there just because like whenever I get me some extra [medication], um, also, well my mom, my stepdad, he was also a diabetic, so my mom sometimes would have like extra ones, so she's supply me with, the same kind of medication, 'cause we'd use pretty much the same, the same dosage, so I'd be able to get them from her or my aunts, uncles, sometimes, you know, if they had some available. Sometimes they'd get samples at the hospitals or whatnot, so I just would use different resources like my family members, who had access to these medications.

Similarly, Lamar (20s, married without children, assistant principal) described learning to "stockpile" medication from his mother. He said that his family growing up had limited financial resources and that he learned from his mother how to stretch medications like that in his inhaler and his insulin. He also learned to reuse needles to inject insulin when resources were limited. As he said, his mother, who was also diabetic,

> used to stockpile 'em. She used to not take it like the way we're s'posed to take it, just to make the medicine last longer, 'cause she had me with asthma, and her with asthma and diabetes. So we had to learn how to manage. So she would stockpile all this medicine, which, good, is good and bad. I still do to this day, like when I knew when I first moved to this state, I didn't have enough money to buy needles every single time. So yeah, if I had to use my needle a second time before I throw it away, till I had single use, I'm like yeah, I'm gonna use this.

By stockpiling medications and redistributing them to their network of family members and close friends, informants share their ability to navigate around the costs of the US healthcare system and create new and better opportunities for using their social capital, much like how financial resources are managed. Two informants, both women, mentioned learning which US-based physicians would "trade" Mexican drugs for samples. Each would take medications purchased in Mexico to their physician's office and trade the office staff to ensure that they were not taking poor-quality drugs. Their physicians would not merely give out samples, but in order to prevent their patients from consuming unregulated medication, they would make these trades. Both of these informants mentioned this strategy as a way to alleviate additional costs and stockpile US-produced drugs at Mexican prices; unbeknownst to their physicians, they were keeping Mexican drugs beyond those they traded in.

These women are not only building CHC but are also actively managing resources to ultimately attenuate compounded vulnerabilities they or their families may face in the future.

Women participants reinforced their familial capital through the continuation of traditional healthcare practices, such as the use of herbal remedies passed down through multiple generations. These practices highlight how women, as health managers and keepers of "treatment know-how," continue to cultivate capital even after the healthcare shopping trip.

General Discussion

CHC goes beyond medical knowledge, encompassing symbolic, direct, and indirect resources that, when coordinated, facilitate patients' access to healthcare. These include familial, social, navigational, and linguistic capital, which can vary across social contexts and over time (Madden 2015). Utilizing these forms of capital can empower patient-consumers to navigate physician encounters, influence care choices, and bridge gaps between patients and providers (Amaro et al. 2024; Shim 2010).

This research examines mostly women, and some men, who travel to Mexico for healthcare. The data show that women use and develop CHC as individuals in ways that are consistent with how companies use and develop financial capital. Yet, our conceptualization of "what is capital" is broadened by viewing women consumers seeking healthcare in two markets to overcome vulnerability experienced in the US market as a result of a lack of affordability and accessibility. Women participants engage in activities that are consistent with treating CHC as wealth or an asset, such as talking to friends and family members, providing healthcare advice, creating and sharing safety strategies, thinking and planning ahead, bringing products back for others, stockpiling medication and other remedies, and distributing "treatment" to family members. Further, in an optimal configuration of CHC, the whole is more valuable than the sum of the parts as consumers navigate transnational markets.

These findings reflect that pre-shopping efforts for strategic planning and capital-building lead to greater efforts to make, build, acquire, and deploy navigational and familial capital. Upon engaging in shopping in Mexico, informants leverage their familial, social, and linguistic capital to garner better, more innovative treatment options, reduce healthcare costs, and increase accessibility for themselves and their families, even if women are managing all of these tasks for their family without the help or input of other family members. Finally, post-shopping efforts reflect efforts to stockpile and redistribute resources in an effort to ensure the well-being of the family and to reinvest in creating sustainable cultural health practices to make additional social capital. In doing so, our informants assume responsibility for organizing appointments, evaluating providers, and managing cross-border care pathways for their households.

Theoretical Contributions

This study offers several important contributions to the service and healthcare literature by advancing our understanding of how women, as healthcare decision-makers, coordinate and manage assets within the complex cross-border healthcare market. By focusing on women's use of CHC, we extend existing theories on consumer vulnerability and capital orchestration in service contexts. Specifically, our research highlights how our participants strategically deploy and create CHC across phases of the shopping journey.

First, this research provides a novel exploration of *cultural health capital* within the context of cross-border healthcare. Previous studies have examined social, financial, and cultural capital in various consumer contexts, but CHC has been underexplored in marketing, particularly in relation to healthcare service experiences. We show that CHC, encompassing knowledge of healthcare systems, cultural practices, and social networks, is a vital resource for women managing healthcare across borders, and stages of the shopping experience. We demonstrate that women are not merely passive recipients of healthcare services but are instead actively co-creating value through their management of capital (e.g., navigational, familial), strategic planning, and ongoing coordination of cross-border healthcare activities (Iacobucci and Popovich 2022; Sharma and Conduit 2016). Women participants use this capital to overcome barriers to care, such as financial limitations and access issues, and to create new forms of CHC by learning, sharing, and growing knowledge within their social and familial networks. This extends the literature on capital usage in service settings, demonstrating that CHC plays a pivotal role in consumer decision-making.

Second, we contribute to the literature on *consumer vulnerability* by illustrating how consumers respond to structural constraints and intersecting identity factors and proactively strategize, organize, and build assets to ensure their families' healthcare needs are met. In doing so, we bring clarity to structural constraints and their implications for structural vulnerability as well as how they are manifested in various stages of the shopping journey. We challenge the prevailing view of vulnerable consumers as reactive or constrained by their circumstances. Instead, we highlight how these consumers leverage their existing capital to build resilience, create opportunities for future care, and respond to structural constraints by *creating new structures* for service provision. These efforts are particularly critical to understanding how community-supported markets may be better at responding to different care needs (Chatzidakis et al. 2025).

Third, we respond to calls for research on *disadvantaged consumers and underserved communities* (Field et al. 2021) by providing empirical insights into how women in marginalized communities use CHC to manage cross-border healthcare shopping. Our findings emphasize that women participants are not

only engaging in traditional caregiving roles but also taking on managerial tasks in organizing healthcare for their families. In doing so, they strengthen familial ties and expand their networks of social and navigational capital. This adds a new dimension to the study of consumer behavior in vulnerable markets, showing how familial, social, navigational, and linguistic capital are coordinated and redistributed to ensure continued access to care in dynamic healthcare environments. Furthermore, it complements prior work about how social identities and cultural backgrounds significantly impact their behavior and expectations in service encounters (Bone et al. 2014; Grier et al. 2024).

Finally, this study contributes to *transformative service research* (TSR) by highlighting how women co-create value for themselves and their families while navigating two healthcare systems (Anderson and Ostrom 2015; Rahman 2021). TSR focuses on how service systems can enhance well-being and quality of life for individuals and communities, and our research extends that focus by examining how women, in their roles as healthcare managers, orchestrate assets to improve the chances of positive outcomes. Moreover, we show that women's interactions with service providers affect their personal healthcare experiences, along with creating positive and negative spillover effects for their families and broader social networks.

Practical Implications

The findings of this research have several implications for improving service outcomes for vulnerable consumers. By examining how Hispanic women in the US–Mexico borderlands use CHC to navigate structural barriers to care, this study highlights opportunities for improving service design and consumer well-being from a lens of transformative service research. Importantly, our findings should not be interpreted as suggesting that cross-border healthcare navigation is inherently beneficial. Participants often experienced subjective benefits (e.g., reduced costs, shorter wait times, and greater perceived control) yet these advantages do not necessarily guarantee safer or more effective clinical outcomes. One implication, therefore, is that healthcare systems should focus on reducing the need for consumers to rely on complex or risky navigation strategies in order to obtain care.

First, healthcare organizations can improve service design by recognizing the forms of CHC consumers bring to healthcare encounters, including navigational, social, familial, and linguistic capital. In our context, women frequently coordinated care across US and Mexican systems by drawing on prior experience, family networks, and bilingual communication. Providers should recognize that cross-border care often includes routine services. Culturally and linguistically responsive service design, including bilingual materials, interpreter-on-demand services, and clearer referral and follow-up communication, can reduce friction in service encounters and help ensure consumers are not left to navigate complex clinical decisions without adequate support (see Table 2).

Second, our findings suggest that healthcare co-creation often begins before formal service encounters and continues after they end. Women in our study actively coordinated scheduling, provider selection, information gathering, and post-visit care across fragmented systems. Service providers can better support vulnerable consumers by designing touchpoints that acknowledge and relieve this burden rather than assuming it is invisible household labor. Examples include evening and weekend access, clearer episode-based pricing, caregiver registration options, and cross-border discharge summaries that facilitate continuity of care. These measures recognize consumers' contextual expertise while reinforcing the importance of professional clinical guidance.

Third, the implications of our findings extend beyond border communities. In the post-Dobbs landscape, increasing restrictions on reproductive healthcare in parts of the US may compel more consumers to travel across state or national borders for maternal and reproductive care. As a result, many individuals may face similar challenges to those observed in our study—mobilizing networks, interpreting unfamiliar systems, and coordinating travel under time-sensitive and stigmatized conditions. In these contexts, CHC may again function as a crucial navigational resource, yet reliance on it also signals gaps in accessible and coordinated care. From a service systems perspective, the goal should not be to encourage increasingly complex healthcare mobility but to reduce the structural barriers that make such navigation necessary.

Finally, a TSR perspective highlights the importance of improving well-being by reducing the burdens placed on vulnerable consumers. In our sample, women frequently assumed responsibility for translation, logistics, and risk management for themselves and their families. Healthcare organizations and policymakers can support consumer well-being by developing more coordinated and transparent care pathways, including improved communication across providers, clearer information about treatment options and costs, and stronger cross-border collaboration. Recognizing the value of CHC is important, but the broader objective should be to design healthcare systems that do not require vulnerable consumers to navigate complexity so skillfully in order to receive appropriate care.

Designing Safer Pathways for Vulnerable Healthcare Consumers

From a transformative service research perspective, the implication of our findings is not that vulnerable consumers should become ever more skilled at navigating fragmented systems. Rather, service systems should be designed to reduce the burden of risky strategizing. This means creating safer, more coordinated, and more culturally responsive pathways for consumers who already rely on cross-border care.

Table 2. Practical Service Design Implications for Common Healthcare Service Providers.

Service Provider Type	Service Touchpoint Friction (Per the Data)	Service Design Implication to Reduce Structural Vulnerability
Primary care providers	Weekday-centric schedules, long waits, and months-long delays limit timely access and continuity of care.	Add evening/weekend appointments, walk-in capacity, bilingual intake, and telehealth options that support continuity rather than substituting for follow-up care.
Specialist practices	Referral bottlenecks and long queues delay needed evaluation; some participants sought more direct access in Mexico.	Offer expedited triage pathways, proactive referral-status updates, and scheduling support that helps patients obtain timely specialist care.
Hospitals	Cross-system continuity gaps create risk during discharge, recovery, and follow-up.	Provide discharge packets with plain-language aftercare instructions, medication guidance, and record-sharing protocols that facilitate safe follow-up with outpatient providers.
Pharmacies	Access barriers and prescribing differences may push consumers toward self-directed medication acquisition, creating misuse risk.	Incorporate brief pharmacist safety checks for higher-risk medications, bilingual counseling, and clear labeling that encourages appropriate use and referral to clinical evaluation when needed.
Urgent care and emergency clinics	Scope-of-care uncertainty and variable pricing make it difficult to determine when urgent, emergency, or follow-up care is appropriate.	Post clear scope-of-care guidance, transparent pricing for common visits, and referral instructions that direct patients to higher-acuity or follow-up care when clinically indicated.
Dental clinics	Cash quotes may appear attractive, but unclear downstream charges and aftercare needs create financial and treatment uncertainty.	Offer bundled estimates with all expected fees listed up front, clear explanations of possible additional treatment needs, and aftercare guidance that supports care continuity.
Imaging and labs	Order routing confusion, preparation uncertainty, and delays in results-sharing can interrupt diagnosis and follow-up.	Provide simple preparation instructions, transparent queue information, and timely results release that can be shared directly with referring and follow-up providers.
Medical billing services	Opaque copays and add-on charges make total costs difficult to anticipate, complicating care planning.	Provide total-episode estimates and plain-language billing explanations that support informed planning while reinforcing the value of timely preventive and follow-up care.
Insurers and benefit managers	Network maps, benefits, and out-of-pocket responsibilities are difficult to interpret; limited recognition of cross-border care complicates continuity.	Provide plain-language network maps, pre-service cost estimates, and benefit designs or riders that support coordinated routine cross-border care while preserving continuity, emergency coverage, and follow-up within formal systems.

Note. These implications are intended to support safer coordination between consumers' contextual expertise and providers' clinical expertise, not to substitute lay navigation for professional care.

For service providers and policymakers, this could include improving access to bilingual information, strengthening care coordination across service encounters, increasing price transparency alongside clinical guidance, and reducing the structural barriers that push consumers toward unsupervised decision-making. Framed this way, CHC is not simply a consumer asset to be celebrated; it is also evidence of the compensatory labor vulnerable consumers perform when formal systems fail to deliver accessible, trustworthy, and affordable care. A TSR lens therefore shifts the focus from admiring consumer ingenuity alone to redesigning services so that well-being does not depend on consumers having to navigate risk so skillfully.

Boundary Conditions and Risks in CHC-Enabled Navigation

Although our findings show how participants mobilize CHC to navigate structural barriers to care, these strategies also have important limits. Cross-border navigation was often adaptive in the face of high costs, long wait times, and perceived stigma in US healthcare, but it did not always ensure safer or better clinical outcomes. In this sense, CHC may generate subjective value—such as cost relief, faster access, and greater perceived control—without necessarily producing objective improvements in health outcomes.

Some participant practices also reveal forms of technical vulnerability. For example, accounts of medication sharing, stockpiling, and treatment decisions made without full clinical confirmation suggest that navigational skill can at times substitute for, rather than complement, professional safeguards. These practices may help consumers manage immediate constraints, but they can also introduce risks related to delayed diagnosis, inappropriate treatment, or medication misuse.

More broadly, our findings highlight healthcare as an expert service characterized by interdependent forms of knowledge. Providers contribute clinical and diagnostic expertise, while patients and caregivers contribute contextual expertise about family needs, prior experiences, cultural norms, financial constraints, and the practical realities of navigating care across settings. In this context, CHC is best understood as a form of contextual expertise that helps consumers access, interpret, and coordinate care across fragmented systems. Importantly, however, this expertise complements rather than replaces professional clinical judgment. Recognizing this interdependence helps clarify both the value and the limits of CHC: it can improve navigation and communication, but it cannot substitute for the safeguards embedded in formal diagnosis, treatment planning, and follow-up care.

These findings point to an important boundary condition: CHC is most beneficial when it helps consumers access, interpret, and coordinate care, but it becomes riskier when it is forced to stand in for professional clinical expertise. In expert services such as healthcare, patients and caregivers contribute critical contextual expertise about family needs, histories, and constraints, while professionals contribute diagnostic and treatment expertise (Azzari et al. 2021). Our findings therefore suggest that CHC should be understood as a vital navigational resource, but not as a replacement for clinical oversight.

Limitations and Future Research

While our study provides valuable insights into the intersection of structural vulnerability and identity factors, and the use of CHC in cross-border healthcare, several limitations present opportunities for future research. First, the relationship between health and economic resources remains an underexplored area. Although we focused on CHC, future studies could investigate how individuals and communities manage health and economic capital together to achieve optimal outcomes. Exploring broader resource management strategies could reveal how different forms of capital—such as financial, social, and cultural—interact to shape healthcare decisions and outcomes.

Second, our study utilized a naturalistic inquiry into women's cross-border healthcare shopping, providing a rich contextual understanding of their experiences. Future research could expand to other social contexts and consumer groups to explore how vulnerable consumers develop strategies to overcome healthcare disenfranchisement. Investigating various cultural and economic environments may yield new insights into collective strategies for navigating healthcare systems. Additionally, since cross-border healthcare shopping is relatively new for some US consumers, further research could explore the forms of capital used at different stages of the shopping process in the US and Mexico, especially among those managing chronic illnesses or unexpected catastrophic events. We do not claim broad generalizability to all women or all forms of healthcare travel, as our sample consisted primarily of Hispanic women and the men who depended on them to manage their cross-border consumption of care. Thus, future research could also be expanded to additional samples for further exploration of their use of capital.

Moreover, while we focused on CHC, other forms of capital, such as *resistance capital* (Yosso 2005), may also play a critical role in healthcare shopping. Particularly because many consumers experience disenfranchisement due to interconnected factors such as gender-, social class-, and immigration-based inequalities (Crockett et al. 2011), future research could explore how consumers activate or inactivate different types of capital at various stages of the shopping experience and across the broader consumer healthcare journey. These studies would deepen our understanding of how consumers strategically adapt to healthcare system constraints and leverage multiple forms of capital to manage their health needs.

Our study also raises concerns about potential unintended consequences of increased consumer agency in healthcare decision-making. Empowering consumers to navigate healthcare systems independently can lead to "responsibilization" (Anderson et al. 2016; Chatzidakis et al. 2025), where individuals bear the burden of managing their health with limited support from the healthcare system. This shift may result in suboptimal outcomes as consumers take on more responsibility without adequate guidance from professionals. Future research should explore how to balance consumer agency with healthcare system accountability.

Conclusion

When consumers rely on multiple healthcare markets, such as those of the US and Mexico, they encounter both expanded access to services and heightened risks related to fragmented coordination, uneven oversight, and variable clinical safeguards. Our findings show that CHC helps vulnerable consumers navigate these constraints. Through the strategic use of navigational, social, familial, and linguistic resources, the Hispanic women in our study coordinated care across two national systems, managing appointments, treatments, and information flows across pre-shopping, during-shopping, and post-shopping phases of care.

Importantly, the mobilization of CHC should not be interpreted as evidence that cross-border healthcare navigation is inherently beneficial or safe. Rather, it reflects the extensive labor vulnerable consumers undertake to secure timely and affordable care in fragmented service environments. While

these strategies may generate subjective benefits, such as reduced costs, shorter wait times, and greater perceived control, they do not necessarily ensure improved clinical outcomes. Instead, the need for such navigation highlights structural frictions within healthcare systems that shift coordination and risk management onto patients and their families.

By documenting how women coordinate healthcare across national boundaries, this research extends understanding of consumer vulnerability in complex service ecosystems and advances the CHC framework by showing how it is cultivated and mobilized within families over time. Ultimately, the goal for service systems should not be to rely on vulnerable consumers to navigate healthcare more skillfully, but to reduce the need for such navigation by addressing structural barriers to safe, accessible, and coordinated care.

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Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The authors gratefully acknowledge financial support from Blue Cross Blue Shield and research assistance from Emilia Amaro and Nayana Guerrero.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Supplemental Material

Supplemental material for this article is available online.

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